Nos. 89-1391, 89-1392

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

DR. IRVING RUST, *et al.*,
Petitioners,

v.

DR. LOUIS SULLIVAN, or his successor,
Secretary of the United States Department
of Health and Human Services,
Respondent.

THE STATE OF NEW YORK, *et al.*,
Petitioners,

v.

DR. LOUIS SULLIVAN, or his successor,
Secretary of the United States Department
of Health and Human Services,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF TWENTY-TWO BIOMEDICAL ETHICISTS AS AMICI CURIAE SUPPORTING PETITIONERS

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INTEREST OF AMICI CURIAE *

Amici are a group of 22 physicians, attorneys and others who teach medical ethics, or who have a major professional interest in medical ethics. Although the precise beliefs and practices of the members of this group

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* Counsel of record to the parties in this case have consented to the filing of this brief and letters of consent have been filed with the clerk pursuant to Rule 37.

vary, the members believe that permitting patients to make important, personal medical decisions in consultation with their physicians is a fundamental principle of medical ethics, and that the tradition of unfettered physician-patient dialogue is central to that principle. Permitting the government to dictate the medical information that can be provided in the doctor-patient dialogue would undermine principles of medical ethics and compromise principles of good patient care and medical practice to the detriment of patients and physicians alike.

SUMMARY OF ARGUMENT

Patients have a liberty interest in receiving complete and uncensored information about medical alternatives when seeking medical advice or counseling. This Court articulated the liberty interest in bodily integrity in the recent case of *Cruzan v. Director, Missouri Department of Health*. A constituent element of that right and the doctrine of informed consent is the receipt of full information about the patient's medically appropriate options and the risks related to each.

This liberty interest in full medical disclosure has its source in both medical ethics and common law precepts concerning the physician-patient relationship. Under established law and practice, patients have come to rely on physicians and other health care professionals for all medical information necessary to permit them to make informed decisions about their own health care.

The Title X counseling and referral regulations challenged in this case infringe this liberty interest. The imparting of incomplete medical information can pose serious health dangers to patients. Title X patients are particularly threatened, because they often have no other source of medical advice.

There is no government interest justifying this infringement on the patient's liberty interest. The fact that the challenged Title X restriction is a condition of federal funding is constitutionally inconsequential.

ARGUMENT

I. PATIENTS HAVE A CONSTITUTIONALLY PROTECTED LIBERTY INTEREST IN EXERCISING CONTROL OVER THEIR OWN MEDICAL TREATMENT DECISIONS, AND THAT INTEREST IS INFRINGED BY THE TITLE X COUNSELING AND REFERRAL RESTRICTIONS.

Amici concur in petitioners' argument that the Title X regulations restricting abortion-related counseling and referrals[1] conflict with Title X of the Public Health

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[1] *Amici*'s discussion is directed at the counseling and referral regulations at issue in this case, 42 C.F.R. § 59.8 (1989), which provide in pertinent part:

> (a) (1) A Title X project may not provide counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning.
>
> (2) Because Title X funds are intended only for family planning, once a client served by a Title X project is diagnosed as pregnant, she must be referred for appropriate prenatal and/or social services by furnishing a list of available providers that promote the welfare of mother and unborn child. She must also be provided with information necessary to protect the health of mother and unborn child until such time as the referral appointment is kept. In cases in which emergency care is required, however, the Title X project shall be required only to refer the client immediately to an appropriate provider of emergency medical services.
>
> (3) A Title X project may not use prenatal, social service or emergency medical or other referrals as an indirect means of encouraging or promoting abortion as a method of family planning, such as by weighing the list of referrals in favor of health care providers which perform abortions, by including on the list of referral providers health care providers whose principal business is the provision of abortions, by excluding available providers who do not provide abortions, or by "steering" clients to providers who offer abortion as a method of family planning.
>
> (4) Nothing in this subpart shall be construed as prohibiting the provision of information to a project client which is medically necessary to assess the risks and benefits of differ-

Service Act, Pub. L. No. 91-572, 84 Stat. 1504 (codified as amended at 42 U.S.C. §§ 300-300a-6a (1989)), and with the first and fifth amendments to the United States Constitution, and believe that the decision of the court below must be reversed on these grounds. In addition, *amici* believe that these regulations are constitutionally infirm because they compel physicians and clinicians to violate their professional obligations to provide patients with complete and accurate medical advice, and undermine patients' legitimate expectation that medical advice will include full disclosure of relevant alternatives, thus infringing the rights of patients under the due process clause of the fifth amendment to the United States Constitution.

A. Full and Informed Disclosure of Medical Options Is Integral to the Right of Patients to "Bodily Integrity" Recognized in *Cruzan*.

The principle that a patient is entitled to complete disclosure from her physician of the risks of and alternatives to medical treatment is basic to medical ethics. This principle applies from the initiation of medical consultation to a successful medical outcome. It reflects the established belief that patients should have control over their own medical treatment decisions, and that patients consult physicians with the legitimate expectation that medical advice will be full, frank, and uncensored. Consequently, a cardinal premise of the medical profession is that "[t]he patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. . . . The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice." *Current Opinions of the*

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ent methods of contraception in the course of selecting a method; *provided*, that the provision of this information does not include counseling with respect to or otherwise promote abortion as a method of family planning.

Council on Ethical and Judicial Affairs of the American Medical Association ¶ 8.08 (1989) [hereinafter *AMA Current Opinions*].

As noted below, these rights and duties are embodied in the medical profession's ethical canons, in the common law of most states, in the statutes of several states, and in decisions of this Court. The Title X restrictions on counseling and referrals are flatly inconsistent with these ethical and legal principles, and would in fact compel grantees to violate them by denying patients relevant and necessary medical information.

This Court has strongly intimated that "bodily integrity" and the right of a patient to exercise control over her own treatment decisions are basic constitutional liberties. In *Cruzan v. Director, Missouri Department of Health*, —— U.S. ——, 58 U.S.L.W. 4916 (1990), the Court suggested that a person has a cognizable liberty interest in refusing unwanted medical treatment. The Court in *Cruzan* stated that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions,"[2] although it recognized that so significant a constitutional principle should not be defined without the benefit of a case or controversy to "inform the inquiry." *Cruzan*, 58 U.S.L.W. at 4920. *See also id.* ("the logic of the cases . . . would embrace such a liberty interest"); *id.* at 4922 (O'Connor, J., concurring) ("I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions").

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[2] Although portions of the Court's analysis in *Cruzan* focused on the specific situation in which a competent person seeks to refuse life-sustaining medical treatment, the Court relied upon other cases recognizing "a general liberty interest in refusing medical treatment," *Cruzan*, 58 U.S.L.W. at 4920, including *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905) (recognizing an individual's liberty interest in declining an unwanted smallpox vaccine).

As the Court observed in *Cruzan*, our culture's recognition of the patient's right of self-determination in medical decisionmaking is expressed in the common-law doctrine of "informed consent"—a doctrine the Court described as "firmly entrenched in American tort law." 58 U.S.L.W. at 4918. The informed consent doctrine, however, embraces more than the right of a competent patient to decline medical treatment. It also embraces a patient's legitimate expectation of complete disclosure by the physician of the risks of the recommended course of treatment and of all reasonable medical alternatives. Indeed, it is this latter conception that is encompassed by the word "informed" in the term "informed consent." As is illustrated below, the informed consent doctrine has come to include, both in the ethical canons of the healing professions and in the legal principles governing the rights and duties of physician and patient, a broad right on the part of patients to have complete medical information before their consent to a particular course of medical action can be regarded as valid. Just as the patient has a liberty interest in declining unwanted medical treatment, she has a liberty interest in receiving the complete and uncensored medical information that permits informed medical decisionmaking.

B. The Medical Profession's Ethical Standards Embody The Doctrine of Informed Consent and Embrace a Duty to Counsel Patients on All Legitimate Treatment Alternatives.

A physician's duty to provide patients with complete information is not merely a requirement imposed on physicians by courts and legislatures.[3] It emanates from

[3] As a recently-convened Presidential Commission has observed, the informed consent doctrine, in addition to having its foundation in law, "is essentially an ethical imperative." 1 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* 2 (1982) [hereinafter *Making Dec*].

the medical profession's own ethical imperatives, which have guided the practice of medicine at least since the days of Hippocrates. For example, Plato included patient autonomy in his definition of individual freedom:

> The free practitioner who, for the most part, attends free men, treats their disease by going into things thoroughly from the beginning in a scientific way, and takes the patient and his family into his confidence. . . . He does not give his prescriptions until he has won the patient's support.

Plato, *Laws*, 4720b-e.

The doctor-patient relationship described by Plato has become the model for modern medical ethics based on the principle of patient autonomy: the patient voluntarily seeks medical advice or assistance; the doctor assesses the medical options and discusses them with the patient; and together they decide upon a course of action, whether it be treatment or referral to another physician. This relationship is privileged and confidential in order to protect the patient's right to bodily autonomy[4]—to decide on his or her medical treatment. The ethical and legal doctrine of informed consent has developed in order to foster and enhance the doctor-patient discussion and facilitate the process of shared decisionmaking essential to a patient's ability to make knowledgeable medical choices.

The principle of medical disclosure, while always oriented to the patient's best interests, has evolved over

[4] The right to bodily autonomy, referred to in *Cruzan* and discussed below, has been recognized in other contexts by this Court as a constitutionally protected liberty interest. *See, e.g., Winston v. Lee*, 470 U.S. 753 (1985) (fourth amendment prohibits forced surgery unless state has more substantial justification than traditional probable cause); *Schmerber v. California*, 384 U.S. 757 (1966) (fourth amendment requires more than probable cause to justify extracting blood without defendant's consent); *Rochin v. California*, 342 U.S. 165 (1952) (due process prohibits forced stomach pumping).

time. At one time, medical ethics followed a *therapeutic* model which countenanced departures from full disclosure if such disclosure was deemed inimical to a patient's best medical interests. *See Salgo v. Leland Stanford, Jr. University Board of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957) ("[I]n discussing the element of risk a cetrain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.") *See generally* R. Faden & T. Beauchamp, *A History and Theory of Informed Consent* 74-88 (1986). More recently, this paternalistic approach has given way to an *autonomy* model, which for the most part disavows the notion that restrictions on disclosure can be in the patient's best medical interests. *See* I *Making Decisions*, *supra*, at 32-39 (discussing the shift from "medical paternalism" to "patient sovereignty").

The primacy of patient autonomy and the related duty of the doctor to encourage such autonomy was first expressed in a 1960 decision in which the Kansas Supreme Court observed that:

> Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. *A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.* (Emphasis supplied)

Natanson v. Kline, 186 Kan. 393, 406-07, 350 P.2d 1093, 1104 (1960).

Today, there is a clear societal consensus that patients have an inherent right to exercise choice in medical decisionmaking, and that physicians have a corresponding

obligation to provide information on alternatives necessary to permit patients to make fully informed choices. The physician-patient relationship, which is private by nature, especially requires openness and freedom to discuss treatment options frankly. As repeatedly noted in the standard medical ethical texts, "[e]thically valid consent is a process of shared decisionmaking based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of particular treatments." 1 *Making Decisions*, *supra*, at 2. In order to make decisions about their care, patients "must have all relevant information regarding their condition and alternative treatments." *Id.*

The ethical foundation of the modern doctrine of informed consent is personal autonomy and self-determination.[5] *Id.* at 44-51. This foundation has been well described by Professor Shultz:

> Individuality and autonomy have long been central values in Anglo-American society and law. In general, the more intense and personal the consequences of a choice and the less direct or significant the impact of that choice upon others, the more compelling the claim to autonomy in the making of a given decision. Under this criterion, the case for respecting patient autonomy in decisions about health and bodily fate is very strong.

Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 Yale L.J. 219, 220 (1985) (footnotes omitted). *See also* Dworkin, *Autonomy and Informed Consent*, *in* 3 *Making Decisions*, *supra*, at 63-81.

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[5] A patient's right to complete and candid medical advice is also founded on the related ethic of promoting personal well-being. Full disclosure fosters personal well-being by giving each patient an opportunity to select the course of treatment that best satisfies his or her own complex set of preferences, rather than relying on the physician's speculation about what would be optimal for the patient. 1 *Making Decisions*, *supra*, 42-44.

The medical ethic underlying the informed consent doctrine also is expressed in the American Medical Association's "Principles of Medical Ethics," which provide with respect to informed consent that:

> [T]he patient's right of self-decision can be effectively exercised *only if the patient possesses enough information to enable an intelligent choice.* The patient should make his own determination on treatment. The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for his care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.

AMA Current Opinions, *supra*, at ¶ 8.08 (emphasis supplied); *see also id.* at ¶ 8.12 (requiring physician to "properly inform the patient of the diagnosis and of the nature and purpose of the treatment undertaken or prescribed. The physician may not refuse to so inform the patient."). AMA policy likewise provides that health care professionals should inform patients of alternative treatments and the related risks: "Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient."[6] *AMA Policy Compendium: Current Policies of the AMA House of Delegates Through the 1989 Interim Meeting* ¶ 32.007(1) (1990).

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[6] As suggested by the quotation in the text, the ethical principle of disclosure is qualified only in certain limited circumstances. The AMA Principles provide that: "[i]nformed consent is a basic social policy for which exceptions are permitted (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated." *AMA Current Opinions*, *supra*, at 32.

AMA guidelines further emphasize the special importance of ensuring a full exchange of information in ethically sensitive situations. The guidelines provide that "[W]hen making treatment decisions that involve ethical choices, health care professionals and patients (or their authorized representatives) should strive for a high level of mutual understanding and shared decisionmaking." *Id.* at ¶ 32.008(1).

These same ethical standards guide the American College of Obstetricians and Gynecologists, which provides in its *Standards for Obstetric-Gynecologic Services* that:

> [i]t is the physician's responsibility to inform the patient of the nature of the surgical or medical procedure being recommended. In most cases, the explanation should encompass the nature of the condition or illness that requires medical or surgical intervention, the recommended course of treatment and its alternatives, the risks and potential complications of the treatment, and its relative chances of success.

American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 88-89 (7th ed. 1989) [hereinafter *ACOG Standards*]. The *ACOG Standards* further provide that a "patient should have an adequate opportunity to ask questions in order to ensure that she understands the information." *Id.*

Importantly, a physician's obligation to provide patients with information needed to ensure informed consent applies even if the physician has only been consulted for advice or diagnosis and will ultimately refer the patient to another health care provider for the actual medical treatment. Indeed, the American College of Obstetricians and Gynecologists standard quoted above refers to "recommended" treatment and does not presuppose that the physician will ultimately perform the procedure elected by the patient. If a physician performing even limited diagnostic and counseling services

becomes aware of medical facts or conditions that should be discussed with a patient the physician has an ethical responsibility to share that information with the patient even if another doctor will ultimately perform any additional therapy or treatment the patient chooses to undergo. *See AMA Current Opinions, supra,* at ¶ 3.05 ("a physician may choose to limit his practice to certain diagnostic services, [but] he may not neglect a patient under his care").[7]

In sum, reflecting prevailing standards of human autonomy and dignity, the medical profession has incorporated into its ethical canons a broad right on the part of patients to make medical treatment decisions based on complete disclosure of medical risks and alternatives. While these canons are not themselves sources of state law or constitutional rights, they are the strongest kind

[7] Courts have recognized a related legal duty to disclose information relevant to procreation decisions, whether or not a physician will even be invoked in providing the relevant medical service. For example, in *Schroeder* v. *Perkel*, 87 N.J. 53, 432 A.2d 834 (1981), the New Jersey Supreme Court held that pediatricians had a duty to disclose to parents the fact that their first child had cystic fibrosis and that any potential future children might be born with that condition as well. Even though the pediatricians would not have provided the pregnancy care themselves, the court found that the parents had a cause of action against them for failing to provide them with sufficient information to make an informed choice about whether to bear a second child. Similarly, in *Dumer v. St. Michael's Hospital*, 69 Wis. 2d 766, 233 N.W. 2d 372 (1975), the Wisconsin Supreme Court held that the doctor had a duty to inform his pregnant patient that she had rubella and that she risked giving birth to a baby with congenital defects, so she could choose whether to give birth or not. The fact that the doctor was not her obstetrician was not relevant.

A physician's duty to disclose also extends to referral to other health care providers for additional treatment if necessary. For example, in *Moore v. Preventive Medicine Medical Group Inc.*, 178 Cal. App. 3d 728, 223 Cal. Rptr. 859 (1986), a California court found that the doctor had a duty to disclose the risk of not being examined by a specialist.

of evidence that a patient's stake in the exercise of a medical choice, based on full disclosure by physician to patient, constitutes a liberty interest that the government may not summarily and arbitrarily extinguish.

C. The Right to Complete and Accurate Medical Advice Is Embodied in State Informed Consent Law.

The legal doctrine of informed consent reflects standards of disclosure and openness in the physician-patient dialogue that are rooted in history and in the medical profession's ethical precepts. The evolution of this doctrine also illustrates the central role of patient autonomy in the medical decisionmaking process.

As this Court observed in *Cruzan*, the doctrine of informed consent "has become firmly entrenched in American tort law." 58 U.S.L.W. at 4818. By holding physicians accountable for failing to apprise patients of the risks attending and alternatives to a particular medical option, state informed consent law affirms the profession's own ethical standards and explicitly recognizes the right of patients to receive full information necessary to make informed decisions about the medical treatment they will, or will not, undergo.

The seminal judicial articulation of the informed consent principle is widely regarded to be Justice Cardozo's statement in *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914), quoted in *Cruzan*, 58 U.S.L.W. at 4917, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." While *Schloendorff* and other early cases announcing the informed consent doctrine were more concerned with the problem of unwanted treatment forced on the unconsenting (and often unaware) patient than with the uninformed or inadequately advised patient,

they were instrumental in defining the legal duty of physicians to respect and to foster their patients' autonomy. *See generally* R. Faden & T. Beauchamp, *supra*, at 123-25.

As of this writing, all but three states have explicitly recognized that a patient's consent cannot be valid unless she has full knowledge of the risks of the particular form of treatment and of legitimate alternatives to that treatment. *See* 3 *Making Decisions*, *supra*, at 193 & n.4. A review of state law demonstrates that the duty of physicians to disclose extends not only to the *risks* associated with a particular medical treatment but also to the existence of medical *alternatives* to that treatment. By failing adequately to notify a patient of available treatment alternatives, the physician in effect fails to divulge sufficient information for the patient to make an inteiligent choice.

That the duty to disclose applies not only to risks[8] but also to medical alternatives was made explicit by the U.S. Court of Appeals for the D.C. Circuit in *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). In considering the duty owed to a patient paralyzed following a back operation who had not

[8] Early cases focused on the duty to inform about the *risks* of a proposed treatment. *See, e.g., Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (duty to inform patient of known risks of a surgical procedure); *Truman v. Thomas*, 27 Cal. 3d 285, 298-301, 611 P.2d 902, 905-08, 165 Cal. Rptr. 308, 320-22 (1980) (duty to inform of danger of failing to undergo pap smear); *Natanson v. Kline*, 186 Kan. at 409-10, 350 P.2d at 1103-07 (1960) (duty to disclose possible risks and consequences of radiation therapy); *McPherson v. Ellis*, 305 N.C. 266, 270-73, 287 S.E.2d 892, 895 (1982) (duty to inform patient of paralysis risk of arteriogram); *Wilkinson v. Vesey*, 110 R.I. 606, 619-30, 295 A.2d 676, 685-90 (1972) (duty to disclose risks of radiation therapy); *Gates v. Jensen*, 92 Wash. 2d 246, 251, 595 P.2d 1155, 1159-61 (1979) (duty to disclose all facts physician "knows or should know which the patient needs in order to make the decision" regarding medical alternatives including in "nontreatment situations").

been warned in advance of this risk, the D.C. Circuit observed:

> The root premise is the concept, fundamental in American jurisprudence, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." *True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.* The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible. (emphasis supplied)

464 F.2d at 780 (quoting *Schloendorff*, *supra*, 211 N.Y. at 129-30, 105 N.E. at 93) (footnote omitted).

Similarly, in *Scott v. Bradford*, 606 P.2d 554, 556-59 (Okla. 1980), the Oklahoma Supreme Court held that the doctor had a duty to disclose not only the risks of hysterectomy surgery but also that there were alternatives to this surgery. Relying on *Canterbury v. Spence*, the Court emphasized that a patient's consent is meaningful only when she is given full information about her medical options: "[t]rue consent to what happens to one's self is the informed exercise of a choice. *This entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.*" *Id.* at 557 (emphasis supplied). *See also Dunham v. Wright*, 423 F.2d 940, 943-46 (3d Cir. 1970) (holding that under Pennsylvania law, patient is entitled to full disclosure of risks and alternatives to surgery); *Archer v. Galbraith*, 18 Wash. App. 369, 567 P.2d 1155 (1977) (holding that physician must inform patients of alternatives to thyroid surgery).

A number of states have by statute explicitly codified the scope of a doctor's duty to disclose both the risks of and alternatives to a proposed course of treatment. For example, New York defines lack of informed consent as "the failure of the person providing the professional treatment or diagnosis to disclose to the patient such alternatives as a reasonable medical . . . practitioner under similar circumstances would have disclosed, in a manner permitting the patient to make a knowledgeable evaluation." N.Y. Pub. Health Law § 2805-d (McKinney 1989). Other statutes mandate disclosure for specific medical procedures. *See, e.g.*, Cal. Welf. & Inst. Code § 5326.85 (Deering 1990) (electroconvulsive therapy); Or. Rev. Stat. §§ 436.205, 436.225 (1989) (sterilization). *See generally* 3 *Making Decisions*, *supra*, 204-51 (describing each state's statutes and/or case law on informed consent).

D. The Patient's Right to Receive from an Advising Physician Information Regarding All Medically Sound Alternatives Applies to Medical Decisions Relating to Procreation.

A physician's duty to advise a patient of available treatment options applies to all medical treatment decisions, including those involving procreation. In particular, whether or not to continue a pregnancy is such a medical treatment decision.

As this Court observed in *Roe* v. *Wade*, 410 U.S. 113, 165-66 (1973), the decision whether to terminate a pregnancy is "inherently, and primarily, a medical decision." The *ACOG Standards* accordingly provide:

> In the event of an unwanted pregnancy, the physician should counsel the patient about her options: (1) continuing the pregnancy to term and keeping the infant, (2) continuing the pregnancy to term and offering the infant for legal adoption, or (3) aborting the pregnancy.

ACOG Standards, *supra*, at 62. That the abortion procedure may be a controversial one, or that some physicians may be opposed to performing it, does not change the fact that abortion is a legitimate medical procedure that is generally regarded as medically indicated under certain circumstances. As such, the same disclosure obligations apply to abortion as to any other legitimate medical alternative.[9]

ACOG's reference to "counseling" is particularly significant. As this Court repeatedly has recognized in considering the constitutionality of state laws regulating abortion, physicians must be free to provide their patients with full, accurate and medically appropriate counseling. Thus, for example, in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), the Court struck down a Pennsylvania statute that compelled physicians to provide various kinds of information to a woman prior to receiving her consent to terminate a pregnancy. The Court characterized the statute's requirements, which it regarded as "the antithesis of informed consent," 476 U.S. at 764, as "nothing less than an outright attempt to wedge [Pennsylvania's] message discouraging abortion into the privacy of the informed-consent dialogue between the woman and her physician." 476 U.S. at 762. Similarly, in *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 443 (1983), the Court observed that "[i]t remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances." *See also Planned Parenthood v. Danforth*, 428 U.S. 52, 67 n.8

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[9] *Cf. Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220 (1984) (hospital required to withdraw life support system, notwithstanding moral objections); *In re Guardianship of Grant*, 109 Wash. 2d 545, 567 n.6, 747 P.2d 445, 456 n.6 (1988) (physician may not frustrate patient's choice of a legitimate alternative because of moral objections, but instead is obligated to refer patient to another physician who may provide treatment).

(1976); *Whalen v. Roe*, 429 U.S. 589, 604 n.33 (1977); *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

These cases do more than adumbrate the scope of the onstitutional right to privacy. They explicitly recognize the constitutional importance of full and unregulated communication between doctor and patient in the abortion context. Indeed, in both *Akron* and *Thornburgh* this Court distinguished sharply between state law restrictions that would promote full and accurate medical advice and those that would inhibit such advice. *Akron*, 462 U.S. at 445-47; *Thornburgh*, 476 U.S. at 759-65. The Title X counseling and referral restrictions at issue inhibit rather than promote informed decisionmaking; they explicitly limit the information and medical choice available to patients.

In addition to the decisions of this Court, there are numerous state court decisions in which information regarding pregnancy and childbirth have been deemed to be within a physician's duty to disclose. For example, in *Berman v. Allan*, 80 N.J. 421, 431-33, 404 A.2d 8, 13-15 (1979), the New Jersey Supreme Court found a physician liable for failing to inform parents of a child born with Down's Syndrome of the amniocentesis procedure that would have detected the condition at a time when the pregnancy could have been aborted. Later, in *Schroeder v. Perkel*, *supra*, the same court held that a doctor who had failed to disclose to his patient that her first child had cystic fibrosis and that there was a high risk that additional children might have the disease could be sued when the patient's second child was born with the disease. In both cases, the New Jersey Supreme Court emphasized the physician's duty to provide information that would have affected the mother's decision whether to respond to a pregnancy by the alternative of childbirth or abortion.[10]

[10] *See also Phillips v. United States*, 566 F. Supp. 1 (D.S.C. 1981) (United States liable in tort for failure of staff at navy medical hospital to give adequate genetic counseling to pregnant patient who subsequently gave birth to infant with Down's Syndrome); *Smith v. Cote*, 128 N.H. 231, 513 A.2d 341 (1986) (holding doctor liable for negligent failure to disclose rubella in pregnant mother, where child was born with congenital deformities and mother would have had an abortion had she known of risk of birth defects caused by rubella during pregnancy); *Jacobs v. Theimer*, 519 S.W.2d 846 (Tex. 1975) (same); *Dumer v. St. Michael's Hospital*, *supra* (same).

E. Title X Restrictions on Counseling and Referrals Infringe the Liberty Interest of Patients in Making Informed Medical Decisions.

It is undisputed that the Title X regulations governing counseling and referrals interfere with the ability of physicians in Title X projects to disclose relevant medical information to their patients, and the corresponding liberty interest of the patients to receive that information. The regulations prohibit physicians at Title X projects even from mentioning abortion as a medical treatment or from identifying providers of abortion services. *See* 42 C.F.R. § 59.8(a)(1) (projects "may not provide counseling concerning the use of abortion as a method of family planning"); *id.* at § 59.8(a)(3) (prohibiting Title X projects from providing referral lists including "health care providers whose principal business is the provision of abortion").

In some cases, the bar against providing full medical information to patients will put patients at serious medical risk. To take only the most obvious example, pregnant women with certain complicating conditions (such as diabetes, hypertension, and cancer) may face serious health risks if they continue the pregnancy. *See* Brief *Amici Curiae* of the American College of Obstetricians and Gynecologists *et al.*, *Rust v. Sullivan* (Nos. 89-1391, 89-1392). Yet, counseling with respect to pregnancy termination would be precluded by the regulations in such

cases save when an "emergency" exists. *See* 42 C.F.R. § 59.8(a)(2).[11] Many situations involving such health risks would not technically satisfy the definition of "emergency," which is left vague but appears from the examples in the regulation to be limited to situations like an ectopic pregnancy. *See* 42 C.F.R. § 59.8(b)(2).

There are many scenarios in which the Title X regulations would compel a physician to violate his or her legal and ethical obligations to provide patients facing particular health risks with full and accurate information about medical treatment options. Furthermore, it is important that the obligation to impart relevant information concerning pregnancy options is not limited to cases involving health risks but rather, as the guidelines of the American College of Obstetricians and Gynecologists state, applies to all medical decisions. The Title X regulations severely restrict such counseling. It would be difficult to imagine a more flagrant interference with a patient's right to accurate and complete information.[12]

II. NO STATE INTEREST JUSTIFIES THE INFRINGEMENT OF PATIENT LIBERTY INTERESTS CAUSED BY TITLE X COUNSELING AND REFERRAL REGULATIONS.

Once a "liberty interest" under the due process clause has been established, "whether [a party's] constitutional rights have been violated must be determined by balanc-

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[11] The regulations provide that "[i]n cases in which emergency care is required, however, the Title X project shall be required only to refer the client immediately to an appropriate provider of medical services." *Id.*

[12] That health care professionals working at Title X projects would not themselves perform medical procedures does not make the counseling prohibition any less intolerable. As discussed above, a physician's failure properly to counsel or to refer patients on whom a medical procedure ultimately will or should be performed by another is inconsistent with standards of informed consent.

ing his liberty interests against the relevant state interest." *Cruzan*, 58 U.S.L.W. at 4920 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)). This analysis, in turn, depends on the interests asserted by the government. The government cannot identify a state interest sufficient to justify withholding from patients medically necessary information.

The government has not to this point argued that, as a general matter, patients are better off with incomplete medical information. Nor has the agency suggested that it has an especially compelling interest in denying information only to poor women, who are the principal beneficiaries of Title X assistance. The sole governmental interest offered in support of the counseling and referral regulations is the government's wish to promote childbirth and discourage abortion. This asserted interest is insufficient to justify so severe an infringement of patient interests in full disclosure of medical options.

By restricting the advice and information that physicians can legally provide to their patients, the Title X counseling and referral regulations seriously impair patient's rights to full and accurate medical information and make it virtually impossible for them to give their informed consent. Through the Title X program, the Department of Health and Human Services (HHS) establishes physician-patient relationships. By initiating such a relationship of trust and then barring the physician from providing full information, the government creates new obstacles to the patient's exercise of her right to make informed medical decisions. First, in the medical doctor-patient relationship, the patient places ultimate trust in the quality of the information received from the physician, and relies on that information being complete. *See* J. Katz, *The Silent World of Doctor and Patient* 142-47 (1984). Moreover, because patients in the Title X projects generally have no other source of professional medical advice, they are especially reliant on receiving full disclosure.

The Title X regulations are in fact so intrusive that they verge on constituting intentional deception. To a substantial degree, the advice poor women receive and rely upon will be that of the federal government, not the independent medical judgment of their doctor. This turns traditional notions of the inviolability of the doctor-patient relationship on their head. Worse yet, in many cases, patients will not realize that they have been given incomplete information.

There is no precedent for prohibiting the flow of information concerning any treatment—whether it be abortion, antibiotics, or surgery—that is generally regarded as medically indicated under appropriate circumstances and whose performance is legal under those circumstances. While the government may assert a variety of interests to support various types of regulation of individual medical decisions, a baseline constitutional principle should be this: There is no substantial governmental interest in limiting medical information about medical procedures that are regarded as legitimate under prevailing medical standards. The government's claimed interest in this case simply does not support its heavy-handed imposition of restrictions on counseling and referral, when weighed against a patient's fundamental liberty interest at stake.

III. THE CONSTITUTION PROHIBITS FUNDING RESTRICTIONS THAT IMPAIR A PATIENT'S RIGHT TO FULL AND ACCURATE MEDICAL INFORMATION.

As the foregoing demonstrates, the federal government may not constitutionally intrude upon the sanctity of the physician-patient relationship by directly prohibiting physicians and health care professionals from informing their patients about all their valid treatment options. It is equally true that the Constitution bars indirect governmental efforts to reach this same result.

The government has argued that the Title X regulations are not subject to constitutional constraints because Title X is merely a funding program and does not directly regulate private conduct. But as this Court has repeatedly observed, "even though a person has no 'right' to a valuable government benefit and even though the government may deny him the benefit for any number of reasons, there are some reasons upon which the government may not act. It may not deny a benefit to a person on a basis that infringes his constitutionally protected interests . . . ." *Perry v. Sindermann*, 408 U.S. 593, 597 (1972). *See also Speiser v. Randall*, 357 U.S. 513 (1958).

Contrary to this established precedent, the Second Circuit concluded that the Title X counseling and referral restrictions could be sustained under authority of *Maher v. Roe*, 432 U.S. 464 (1977), and *Harris v. McRae*, 448 U.S. 297 (1980). We disagree for two reasons. First, from a first amendment perspective, there can be little question that the Title X regulations constitute an impermissible viewpoint-based restriction on speech. The regulations specifically target speech "concerning the use of abortion as a method of family planning," 42 C.F.R. § 59.8(a)(1), and, as such, fall afoul of the Constitution. *See, e.g., Arkansas Writers' Project, Inc. v. Ragland*, 481 U.S. 221 (1987); *FCC v. League of Women Voters*, 468 U.S. 364 (1984).[13]

Second, when seen in the light of the doctrine of informed consent and patient liberty interests in full medical disclosure, the Title X counseling and referral restrictions far exceed anything approved in *Maher* or *McRae*. Both *Maher* and *McRae* involved cases in which the federal government adopted a passive position, choosing not to support particular conduct or speech. But in

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[13] We concur with, and defer to, the more comprehensive treatment of this issue in briefs filed by petitioners and other *amici* in support of petitioners.

this case, HHS has affirmatively intervened in doctor-patient relationships to the detriment of the patients.[14]

The saving distinction drawn in *Maher* was between "direct state interference with a protected activity and state encouragement of an alternative activity consonant with legislative policy." 432 U.S. at 475 (footnote omitted). Similarly, in *McRae* the court observed that "although government may not place obstacles in the path of" an individual's exercise of constitutional rights, "it need not remove those not of its own creation." 448 U.S. at 316.

In sharp contrast to these cases, Title X counseling and referral regulations constitute a "direct state interference with a protected activity." These regulations do not merely favor childbirth over abortion. They require physicians to give partial, misleading medical *information* in direct contravention of their ethical and legal obligations, placing at least some patients in a worse position than if there had been no Title X funding at all. It therefore cannot be said, in contradistinction to *Maher* and *McRae*, that the regulations leave Title X patients in "no worse position" than if no funds at all were provided.

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[14] These cases are also distinguishable because they involved only the use of federal funds, whereas the challenged Title X regulations affect grantees' use of state and private funds as well. *See* 42 C.F.R. § 59.2 (1989) ("Title X project funds include all funds allocated to the Title X program, including but not limited to grant funds, grant-related income or matching funds."). This Court specifically cautioned in both *Maher* and *McRae* that its analysis would change if funding conditions burdened a recipient's ability to independently exercise her constitutional rights. *See Maher*, 432 U.S. at 474 n.8; *McRae*, 448 U.S. at 317 n.19.

CONCLUSION

The restrictions on counseling and referrals constitute an unprecedented effort by the government to exploit the traditional trust of the physician-patient relationship in order to steer needy women's health care decisions in the direction of a medical treatment favored by the government. In so doing, the government forces physicians and health care professionals in Title X projects to provide incomplete and thereby misleading medical advice, and thus to violate the most basic principles of medical ethics and common law. The government has no legitimate countervailing interest in interfering with patients' recognized liberty interest in making informed medical decisions.

For the foregoing reasons, the judgment of the Court of Appeals should be reversed.

Respectfully submitted,

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APPENDIX

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